Healthpoint

Information from the Division of Health Care Finance and Policy

THE UNCOMPENSATED CARE POOL

The Uncompensated Care Pool reimburses acute care hospitals and community health centers for free care they provide and is a critical link in the state's effort to ensure access to health care to the low-income uninsured and underinsured. Currently, there are a number of proposals to expand health care access to a wider range of people while simultaneously relieving hospitals' responsibility for paying the Pool. This issue of *Healthpoint* looks at the history of the Uncompensated Care Pool and some current policy issues surrounding the Pool's funding and policy goals.

Origin and History

In 1985, the Massachusetts Legislature created a funding mechanism to cover bad debt and free care costs in acute care hospitals and their affiliated community health centers. The Uncompensated Care Pool was established to distribute equitably the financial burden of uncompensated care, to reduce cost shifting, and to eliminate disincentives a hospital might have to providing uncompensated care.

Funding for the Pool came from a uniform surcharge on hospitals' private payer charges. Hospitals were required to reimburse the Pool if revenue they received from the surcharge exceeded their uncompensated care costs. If the surcharge failed to cover a hospital's total uncompensated costs, the Pool would reimburse the hospital for those additional costs. Hospitals passed the surcharge on to private payers, who would incorporate the charge into their premiums.

The Pool Gets a Cap

While maintaining many of the essential components of the Pool, comprehensive ealth care legislation in 1988 (Chapter 23) contained an important change. The gislature capped the private sector liability for the Pool at $325 million in FY 1988 nd reduced it periodically through FY 1992. The legislature has since set the private ector liability at the $315 million for Fiscal Years 1993-1996. The business community oped that the cap on its liability would protect it from the increasing surcharges it had been paying since the Pool's creation—up to almost 13.1% of charges in FY 1987—while maintaining the integrity of the Pools funding. Since the advent of the cap, the surcharge has gradually decreased to approximately 6% as of FY 1996.

Healthpoint

Information from the Division of Health Care Finance and Policy

Division of Health Care Finance and Policy

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**Barbara Erban Weinstein
Commissioner**

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The Division of Health Care Finance and Policy.

DHCFP

On July 1, 1996, the Massachusetts Rate Setting Commission and the Department of Medical Security were consolidated to create the Division of Health Care Finance and Policy. Barbara Erban Weinstein is Commissioner of the new Division. The Division is responsible for the information, pricing, and regulatory functions formerly handled by the Rate Setting Commission. In addition, the Division administers the Uncompensated Care Pool, a fund that reimburses Massachusetts acute care hospitals and community health centers for services provided to uninsured or underinsured individuals.

THE UNCOMPENSATED CARE POOL

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Focus on the Low-Income Uninsured

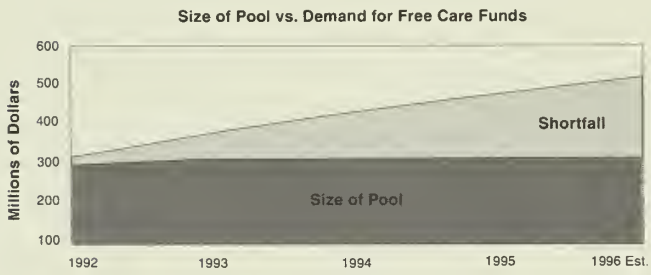
Chapter 495 of the Acts of 1991 retained the private sector cap on the Pool. A significant new provision stipulated that only bad debts generated from emergency services provided to uninsured patients would qualify for reimbursement. Losses associated with all other bad debts (as distinct from "free care" provided to uninsured people meeting low income criteria) would be absorbed by the hospitals that incurred them.

This provision created a stronger incentive for hospitals to collect bad debt instead of writing them off to the Pool.

Current Funding, Allocation and Shortfall

Over the past three years, the Legislature has capped the Pool at $315 million. In addition, the budget has provided to the Pool $15 million from the general fund, financed by federal matching funds. Almost since in inception, the demand for uncompensated care reimbursement has grown while Pool funding has remained relatively constant resulting in a shortfall.

The current method for Pool reimbursement and shortfall allocation reflects a desire to distribute the financial burden of free care in a way that does not competitively disadvantage hospitals providing a large amount of free care.



Chapter 495 instituted this "Greater Proportional Requirement" method which stated that "hospitals with the greatest proportional requirement for Pool income shall receive a greater proportional payment from the Pool."

The Pool methodology assesses each hospital a contribution equal to approximately six percent of private pay charges. The Pool then reimburses a hospital for its free care costs, less the hospital's share of the shortfall, which is uniformly distributed based on size; larger hospitals are responsible for a greater share of the shortfall than smaller facilities. The net result is that a hospital's proportional reimbursement of its free care costs grows with the amount of free care it provides.

The chart on page 3 illustrates this method by showing two hospitals of equal size providing different levels of free care, therefore receiving different levels of reimbursement from the Pool. Both facilities, however, are responsible for the same amount of the shortfall.

The Future of the Pool

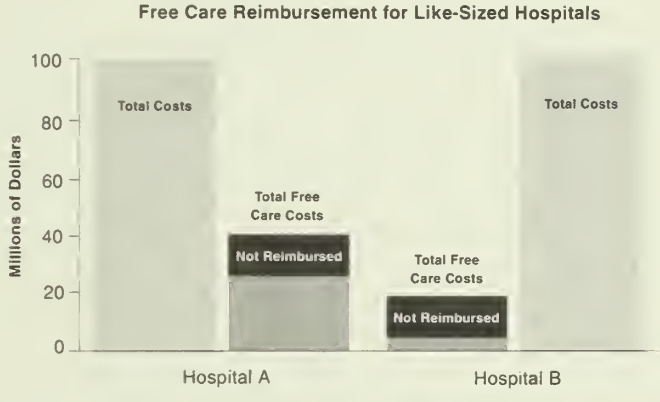
As the dynamics of the health care industry have changed, there has been a corresponding effect on the funding of the Pool. Prior to creation of the Pool, each hospital was responsible for recouping the costs of its own free care and bad debt. The original Pool sought to distribute this burden more equitably.

Chapter 23 brought the cap on private sector liability to the Pool, limiting hospitals' ability to pass uncompensated care costs along to private insurers. The risk for costs exceeding the cap fell to hospitals and, to a small degree, to the Commonwealth.

The competitive market ushered in by Chapter 495 has made more complex the questions of Pool funding. Private sector liability to the Pool remains capped, and many payers now negotiate payment arrangements with hospitals that are not bases on their charges. Hospitals contend that, in this environment, they are less able to collect the surcharge from insurers and are forced to absorb this loss. Insurers argue that their contributions to the Pool are incorporated in the rates they pay to the hospital. With increasing movement toward managed care and innovative payment arrangements, the issue of how the Pool is and should be funded is of increasing concern to the Governor, legislature and all interested parties. A recently enacted law establishes a special commission to recommend a long-term plan to reform the structure of the Uncompensated Care Pool. The special commission will file its plan with the legislature by the end of 1996, and will likely address some or all of the following issues.

Funding Mechanism

Initiatives have been proposed to broaden the Pool's base by expanding the groups paying directly to the Pool. One version would assess commercial insurers, including health maintenance organizations, an annual liability to the Pool. The aggregate liability of acute care hospitals would correspondingly be reduced. A variation of this approach would also prohibit insurers from raising premium to consumers and from reducing payments to hospitals. The insurance industry argues that they would be required to pay the assessment without the ability to raise the necessary revenues. The business community fears insurers would find ways to pass the costs along to employers.



Should the special commission recommend a new funding mechanism for the Pool, the Employee Retirement Income and Security Act (ERISA) of 1974 must be considered. The federal law preempts state employer health coverage mandates and protects self-funded health plans from state "taxes." When health plans in New York used ERISA to challenge a state law requiring hospitals to collect surcharges from them, the U.S. Supreme Court ruled that the economic impact of the surcharge on ERISA plans was indirect and "not substantial enough to trigger preemption." Proposals to broaden the Pool's base should consider such relevant case law.

The commission must also consider that the Commonwealth currently receives $120 million per year in federal matching funds on Uncompensated Care Pool expenditures. To continue to be eligible for these funds, the state must assure the Health Care Financing Administration (HCFA) that its financing methodology satisfies HCFA's rules.

Responsibility for Financing Uncompensated Care

A central issue is how should the financial burden of the costs of uncompensated care be distributed? Hospitals believe they shoulder this responsibility because they actually remit the Pool dollars to the state. Hospitals also contend that when there is a Pool shortfall, it is they who provide the care that may not be reimbursed. Private insurers, by virtue of the fact that they write the check to the

hospital for their enrollee's hospital bill, believe they share in this responsibility as well. Employers and employees may also bear some of the burden through premiums, co-pays and deductibles.

Access for the Uninsured

Opinions differ whether the Pool's purpose is to assist hospitals in financing the care they provide to the uninsured, or to assist low-income citizens to secure adequate health care coverage; policy proposals reflect this debate. Efforts to decrease use of Pool funds by expanding the insured population began under Chapter 23 and continue to the present. Recent legislation has been enacted to increase health coverage for children and the elderly, and to expand Medicaid eligibility. These programs, coupled with existing programs for uninsured individuals at community health centers and medical respite services under Boston's Health Care for the Homeless program, have increased the number of insured citizens in the Commonwealth.

Some argue these programs are incomplete, "band-aid" approaches and that it is the state's responsibility to provide health care for its uninsured and underinsured citizens. Others believe that the money used to reimburse hospitals for uncompensated care might be better spent paying monthly premiums for individuals enrolled in a health plan.

Viability and Longevity of the Pool

Determining the future of funding for uncompensated care in Massachusetts will require balancing the interests of diverse parties—uninsured individuals, providers, insurers, employers, state and federal governments, to name but a few. This is a complicated proposition, made more so by the reality that issues of uncompensated care are intertwined with broader issues of the entire health care system. The membership of the special commission that will consider uncompensated care funding reforms this fall represent a range of opinions; its challenge will be to incorporate those views into a workable consensus.

Did you know?

Hospital Facts

	Massachusetts FY96 Data Submitted to Date	Massachusetts Comparable FY95 Data	Massachusetts FY95	Massachusetts FY94	Massachusetts FY90	U.S. FY94	California FY94
Number of Hospitals							
Acute	79	83	83	87	92	5,229	427
Non-Acute	56	56	56	54	65	811	60
Number of Acute Hospital Discharges (thousands)	364	387	783	823	895	30,718	3,021
Number of Acute Hospital Discharges/1,000 population	***	***	131	137	153	118	94
Number of Acute Hospitel Days/1,000 popuietion	***	***	705	766	1,046	796	529
Acute Hospital Length of Stey	5.29	5.47	5.35	5.68	6.82	6.70	5.60
Percent Inpatient Hospital Ravenues	N/A	N/A	60%	64%	72%	72%	75%
Percent Outpatient Hospital Revenues	N/A	N/A	40%	36%	28%	28%	25%

	Massachusetts Medians					
	FY95	FY94	FY93	FY92	FY91	FY90
Total Revenue ($millions)	73.92	72.46	63.44	57.97	54.10	48.58
Total Expenses ($ millions)	71.31	70.43	62.51	56.95	53.40	48.26
Net Income ($ millions)	1.96	1.10	2.17	1.76	1.09	1.13
Fund Balance ($ millions)	24.29	22.56	18.80	15.47	13.57	13.50
Total Margin	3%	2%	3%	3%	2%	2%

Source: [illegible] Massachusetts Medians. Division of [illegible]

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l. 2 No. 2 January 1997

MANDATED BENEFITS

Health insurance—or, more precisely, those who lack it—currently is center stage in Massachusetts health policy debates. A related subject, mandated benefits for those who *are* insured, has recently acquired a higher profile, not only in Massachusetts but nationally as well.

All 50 states have laws requiring employers that offer group health plans to include specific benefits. Mandates have come to be for a variety of reasons, from public health concerns to political or financial imperatives. The national law requiring a 48-hour hospital stay for uncomplicated childbirth, for example, reflected angry consumer reaction to health plans' aggressive cost control practices. Some mandates receive little criticism, while others are viewed as government intervention at its worst—"meat-ax regulation," in the words of one commentator. This issue of *Healthpoint* highlights some of the policy issues involving health benefit mandates—when mandates may or may not be appropriate, obstacles to their universal application, and the need for rigorous analysis of their effectiveness, both before and after they are put in place.

What are Mandated Benefits?

States typically mandate that insurers cover specific benefits in all health plans sold, but some states more flexibly mandate that each insurer make a service available in at least one plan that it offers. *Provider mandates* require that the services of a certain provider type (chiropractors, for example) be covered by insurance policies. *Benefit mandates* stipulate that the policy include a minimum level of certain benefits:

30 Massachusetts Mandates

		Number of States*
	Provider Mandates	
1	Chiropractors	41
2	Optometrists	37
3	Podiatrists	38
4	Nurse Anesthetists	12
	Nurse Practitioners	18
5	Dental Coverage	34
6	Certified Nurse Mid-wives	30
7	Any-willing provider- pharmacy freedom of choice	**
8	Provider contracts/compensation re: good faith communication	**
	Benefit Mandates	
9	Mental Health Care	32
10	Alcoholism treatment	43
11	Maternity health Care	13
12	Cardiac Rehabilitation	**
13	Home Care	18
14	Mammography Screening	46
	Cytologic Screening (cervical cancer screening)	16
15	Infertility Benefits (includes IVF)	14
16	Non-prescription enteral formulas for home use	**
17	Lead poisoning screening	3
18	Preventive care for children	26
19	Early intervention services for children	**
20	Diethylstilbestrol exposure	**
21	Off-label uses of prescription drugs to treat cancer	**
22	Low protein food products for inherited PKU	9
23	Bone marrow transplants for breast cancer	8
24	Off-label uses of prescription drugs to treat HIV/AIDS	**
25	Hospice Care	**
26	Blood glucose monitoring strips	**
	Coverage Mandates	
27	Dependent coverage for new born infants.	34
28	Coverage for certain period after insured leaves insurance group	36
29	Divorced or separated spouses, continued coverage	**
30	Refusal to contract with blind or deaf persons: prohibition	**

*number of states either mandating offer and/or coverage
**not available

Sources: United States General Accounting Office
Blue Cross Blue Shield Association

Note: In some cases states limit mandates to particular types of health plans such as HMOs or group insurance plans.

Experimental Treatments

In 1995, Massachusetts mandated that insurance companies cover the infertility treatment method called intracytoplasmic sperm injection (ICSI), soon after the American Society for Reproductive Medicine had declared that it was no longer experimental, but an accepted treatment. There have been no long-term studies of ICSI's safety or effectiveness and biologists say that there may be some definitive risks.

the mental illness mandate in Massachusetts requires that firms offer coverage for up to $500 per year for outpatient services and up to 30 days of residential treatment. *Coverage mandates* provide that insurance plans cover a particular class of individual, divorced or separated spouses who were previously covered, for example.

The average state mandates 18 specific benefits. Sixteen states have over 20 mandated benefits, eight have 10 or fewer and Maryland (39), Minnesota (34), California (33) and Massachusetts (30) have the most mandated benefits.

Mandates Do Not Apply to All Insurance

States use mandates to ensure that their citizens receive specific coverage, yet many citizens, although employed and insured, are beyond the reach of the mandates.

The Employee Retirement Income Security Act of 1974 (ERISA) provides a federal framework for regulating employer-based pension and welfare benefits, including health plans. ERISA preemption blocks states from directly regulating most employer-based health plans, but it permits states to regulate health insurers. The General Accounting Office (GAO) estimates 114 million individuals (44 percent of the US population) are covered by ERISA health plans.

In most ERISA plans, the employer purchases health coverage from a third party insurer that is subject to state insurance regulation and insurance premium taxation. But for nearly 40 percent of these plans, covering about 44 million people, the employer chooses to self-fund and retain the risk for its employees' health care costs. Since these self-funded plans are not "insurance," ERISA exempts them from state regulation and premium taxation. If we extrapolate this national figure to the Massachusetts population, an estimated 1.2 million people in the state are in insurance plans that are self-funded and therefore exempt from mandates.

Why mandate?

A philosophical aspect of the debate over mandates involves the imposition of regulation into what is otherwise a relatively free market, with many buyers and sellers. Proponents of mandates focus on equity and access issues. Mandates may protect some insurers from adverse selection—that is, attracting sicker members who are more likely to incur high costs. They may reduce the utilization of more expensive resources by mandating coverage for less-costly alternative services. From a public health standpoint, mandates such as immunization provide access to fundamental services of value to society that some would be unable or unwilling to acquire on their own. Finally, mandates may bring credibility to certain providers.

Why not mandate?

Those opposed to mandates contend that mandates distort costs and interfere with the functioning of the market. Mandates may cause premium costs to rise and encourage some employers to self-fund or discontinue coverage to avoid mandates. There is a risk of over-utilization of medical services, which would lead to rising prices for health services. Mandates might also infringe on

employee-management relations by imposing a benefit package different from what is called for: a "Cadillac" plan where a "Chevrolet" is appropriate.

What is the impact of mandates on costs of insurance?

The cost impact of mandated benefits depends on the nature and scope of each state's regulations and on health plans' typical operating practices. Available studies reflect this cost variation, estimating higher claims cost in states with the most, and most costly, benefits. As an example, Blue Cross Blue Shield of Massachusetts estimates that mandated benefits add 20 percent to their major medical plan rates. In addition, multi-state employers claim that variation in mandates across states adds to administrative costs.

Though mandates may increase costs, estimates of their incremental cost may exaggerate the differences between insured and self-funded health plans. Many commonly mandated benefits are often covered by employers who self-fund, even though they are not subject to state regulation. Studies conducted in the 1980s found that self-funding in order to avoid mandates was a popular strategy for controlling premium costs. This trend is changing, with firms providing more consistent benefits and turning now to managed care to contain costs. Therefore, mandates may cost employers who are technically exempt from them almost as much as those who are not.

Definitive information on the costs and cost effectiveness of existing and proposed mandates is sparse, especially given the potential impact of mandates on the cost of health care. Policy deliberations would seem to demand such cost information, yet studies are limited and inconclusive.

Policy Implications

The universal appeal of some mandates creates the popular impression of a consensus that insurance policies should provide these benefits and that, unless the state requires them, insurers are not likely to include them. This may or may not be the case. If permitted, would insurers eliminate newborn coverage? Probably not. Would they eliminate or reduce coverage of mental health? Possibly. Plans exempt from state mandates cover as many or more benefits as non-exempt plans, suggesting that factors beyond mandates influence coverage decisions. Important policy issues to consider include the costs, effectiveness and appropriateness of mandates, and their effect on access to health care.

Premium costs. The efficacy of state mandates has become an important issue in the debate over reform of the US health care system. Many mandates have been promoted by lobbyists and interest groups for specific health-service groups or patients with certain diseases. The potential cost of these mandates was not a primary consideration. Legislating a two-day maternity stay raises health insurance costs by just a fraction of a percent. In sum, however, mandates contribute what may be significant additional costs that increase premiums.

Cost-Effectiveness Debated

In 1993, arguing against the state insurance mandate of covering IVF treatments, the Massachusetts Association of HMOs calculated that each live birth conceived through IVF cost about $100,000, more than 10 times as much as a complication-free vaginal birth. In 1994, a study of deliveries at Brigham and Women's Hospital found that multiple gestation pregnancies resulting from reproductive technology added more than $3 million a year to the hospital's costs as a result of complications, neonatal intensive care and other expenses. However, according to Resolve, a national infertility advocacy and education organization, the cost to payers of mandated infertility treatment coverage is only 0.4 percent of the monthly premium.

Unintended consequences? An important question in evaluating state-mandated benefits is the extent to which mandating that all insurers include particular health insurance benefits will lead some employers to drop their insurance coverage altogether. Mandates for which the perceived benefits may be the largest (mental illness) are also potentially the most expensive, although it can be argued that preventive services might offset the need for more expensive treatment in the long run. Losing all insurance coverage could have much larger consequence for an individual and for society than gaining coverage for a specific benefit.

Comprehensiveness. States view ERISA as an impediment to ensuring adequate consumer protections for all individuals with employer-based health coverage and to enacting reforms that would improve the efficacy, equity and efficiency of the health care market. States maintain that they should be able to treat all participants uniformly. ERISA makes benefit mandates a less effective tool for accomplishing this goal.

The Need for Analysis. No single analytical tool will be a substitute for the political and social processes required to implement health policy. Cost-effectiveness and cost benefit analyses, however, can organize information in a manner that will allow more reasoned assessments of the options available. A step in this direction is that Massachusetts law now requires rigorous evaluation of the autologous bone marrow transplant and the two-day maternity length of stay benefits.

Conclusion

Mandates heavily influence the health care that a population receives, though an underlying state strategy for health care delivery is often not evident. Policy makers should consider all of the above policy implications, in a systematic way, when considering a new mandate. With health care dollars scarce, they may want to analyze the tradeoffs in cost, access and effectiveness that are implicit in mandating benefits, as well as evaluate those mandates already in place.

Further Reading

[illegible]

Did you know?

Use of the Uncompensated Care Pool

Age Group by Payer

Age Group	Percent of Discharges to Total UC Pool	Medicaid	All Payers
0 — 17	12%	37%	17%
18 — 34	35%	32%	18%
35 — 64	41%	28%	28%
65 & above	12%	3%	37%

Inpatient Major Diagnostic Category by Payer

Top Five Free Care Major Diagnosis Categories	Percent of Discharges to Total UC Pool	Medicaid	All Payers
Circulatory System	11.7%	5.6%	17.1%
Respiratory System	9.6%	8.3%	9.9%
Pregnancy, Child Birth	9.3%	21.0%	11.6%
Mental Disease & Disorders	8.6%	6.2%	4.4%
Digestive System	8.4%	4.8%	8.2%

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HOSPITAL MERGERS AND THE PUBLIC INTEREST

The acute hospital industry has undergone intense restructuring, with many closures, conversions, mergers, acquisitions, and affiliations changing the face of the acute hospital sector in major ways. Nationally, the trend began in the 1980s and has continued into the 1990s. Activity in Massachusetts was slower to start but, with hospital deregulation in 1991 and the continued growth of managed care in the state, consolidation has accelerated considerably. This issue of *Healthpoint* examines the trend and explores some of the pertinent policy issues.

Extent of Consolidation

From 1988 to 1997, 15 hospitals out of 101 in Massachusetts closed or converted to other-than-acute services (one hospital converted from non-acute to acute services). There have been 15 mergers, the formation of six other large systems (under either a common parent or sponsor) and four sales of nonprofit hospitals to for-profit systems (See Figure 1). Consolidation activity has accelerated, with more full asset mergers occurring in 1996 (eight) than in the entire 1988 to 1995 period. Fully three quarters of the state's acute hospitals are now part of some larger network. And many of the hospitals still unaligned are in the midst of discussions with national chains or other systems in the state.

Much of the consolidation nationally has included buyouts of lo-

15 Mergers from 1988 to 1996

1 Berkshire Health Systems
(Berkshire Medical Center, Hillcrest and Fairview)
2 Beth Israel Deaconess Medical Center (Deaconess and Beth Israel)
3 Boston Medical Center (University and Boston City)
4 Cambridge Community Health Network (Cambridge and Somerville)
5 Cape Cod Health Systems (Cape Cod and Falmouth)
6 Good Samaritan (Cardinal Cushing and Goddard Memorial)
7 Health Alliance (Leominster and Burbank)
8 Lahey Hitchcock (Lahey and Hitchcock(NH))
9 Memorial (formerly Medical Center of Central Mass;
Worcester Hahnemann and Worcester Memorial)
10 Metrowest (Framingham Union and Leonard Morse)
11 Northeast Health Systems (Beverly and Addison-Gilbert)
12 Saints Memorial (St. John's and St. Joseph's)
13 Salem (North Shore Children's and Salem)
14 Southcoast Health System (Charlton, St. Luke's and Tobey)
15 UniCare Health Systems (Melrose-Wakefield and Whidden)

Six Other Hospital Systems

1 Baystate Health Systems (Baystate, Franklin and Mary Lane)
2 CareGroup (Beth Israel Deaconess, New England Baptist,
Mt. Auburn, Deaconess-Waltham, Deaconess-Nashoba and
Deaconess-Glover)
3 Caritas Christi (Holy Family, St. Elizabeth's, Carney,
Good Samaritan and St. Anne)
4 Partners (Mass. General, Brigham & Women's, Dana-Farber, Salem
and UniCare Health Systems)
5 Sisters of Providence Health Systems (Providence and Mercy)
6 U Mass Health System (U Mass Medical Center, Clinton and
Marlboro, and loosely with Athol, Henry Heywood,
HealthAlliance, Milford-Whitinsville, Harrington, Noble, Holyoke,
Wing, Berkshire and Hubbard)

Four For-Profit Conversions

1 Vencor purchase of Hahnemann
2 Transitional purchase of JB Thomas
3 Columbia purchase of Metrowest
4 OrNda (now Tenet) purchase of St. Vincent

Figure 1

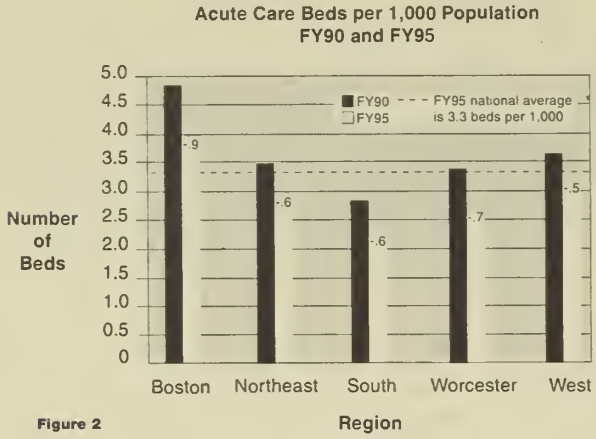

Figure 2

cal hospitals by national chains, whose revenues are growing at a very rapid pace. The largest national chain, Columbia/HCA, increased its net revenues from $300 million in 1990 to $17.2 *billion* in 1995, an increase of over 5,000 percent. Three other national chains - OrNda, Tenet (which is acquiring OrNda) and Catholic Healthcare West - have more than doubled their net revenues in the last five years.

Both Columbia/HCA and OrNda have been active in Massachusetts. Columbia/HCA acquired Metrowest (the merged Framingham Union and Leonard Morse hospitals) last year, and has had recent discussions with many other nonprofit hospitals in the state including, most recently, Neponset Valley Health Systems. OrNda recently acquired St. Vincent Health Care System in Worcester. Lifespan, a nonprofit regional chain, recently announced its intention to purchase New England Medical Center.

The total number of acute hospitals in Massachusetts has dropped from 101 in 1988 to 73 in 1997, and the number of beds per 1,000 population has also been decreasing. Most of this reduction is from hospitals contracting their capacity, rather than from entire hospitals closing. Beds per 1,000, however, continue to be at very different levels across different regions of the state (See Figure 2). Certain areas in the state are still above the U.S. average, while other areas have been consistently below. From the perspective of access and efficiency, it is not clear whether there are now too few beds in these different regions or if capacity could shrink even further without threatening access.

Effects of Consolidation on Industry Efficiency and Prices

Given the driving forces to consolidate in response to the cost-control pressures of managed care, it seems reasonable to ask whether consolidation serves the public interest by promoting a competitive market and a cost-effective health care system. The prevailing theory is that consolidation, along with continued managed care pressures, will reduce incentives for hospitals to duplicate facilities and equipment, and eventually lead to a more rational allocation of resources.

The few studies on cost savings from industry consolidation have been inconclusive as a group on whether mergers and other alliances actually increase efficiency of the system. Some have concentrated on local markets only, where limited competition among a small number of hospitals may have restricted the potential for efficiency improvements. Others have found that efficiencies have been realized but not passed on to purchasers in the form of lower prices. In some cases, where hospitals have traded state imposed post-merger price controls for antitrust approval, there is some evidence of savings. Finally, one national study found that hospitals which merged were able to generate savings, but the researchers could not generalize the results.

A preliminary assessment of cost increases for four of the early mergers in Massachusetts (for which we have at least one full year of post-merger data to assess) is shown in Figure 3. Clearly, there are certain start up costs to consolidation — including the use of attorneys, consultants, and staff time in preparation for the merger, as well as capital costs for restructuring services. For three

of the four mergers, there was an increase in inpatient cost per case mix-adjusted discharge (a measure of efficiency) in the year immediately following the merger. Thereafter, however, the picture is less clear, with some hospital systems showing cost growth lower than the state average for all hospitals, and others higher.

Cost savings, of course, are not the only force driving the rush to consolidate; increased hospital bargaining power is also a powerful incentive. If consolidation results in markets dominated by one or a small number of hospitals, they would be at an advantage in the negotiation process with purchasers and be able effectively to keep any savings that might result from the efficiencies of consolidation. Irrespective of the degree of cost savings achieved, lower prices and premiums are also desirable. Figure 3 shows the change in inpatient net revenue per case mix-adjusted discharge, a good proxy measure for general hospital prices, for the four merged hospitals and the state average. Here, the picture is somewhat clearer for the 1994 to 1995 period. Three of the four merged hospitals show decreases in inpatient prices greater than the decrease in the state average.

Monitoring Consolidation Effects: Competition, Savings and Access

Currently in Massachusetts there is little monitoring of the statewide effects of consolidation on overall market concentration and competition. If consolidation is successful, industry leaders and policy makers should understand how to capture the potential efficiencies hospital mergers offer. This same knowledge would also be helpful to purchasers of health care seeking to achieve savings through reductions in duplication and excess capacity. On the other hand, even if efficiency improves, consolidation could limit competition, enhancing market power and fostering price increases. These potential outcomes suggest that continued post-transaction monitoring of the health care market in Massachusetts is in the public interest.

Access to services in a rapidly changing landscape, particularly when a for-profit conversion is in the works, is a policy concern as well. Most observers agree that measuring changes in access is a complex and multifaceted issue, with no clear cut methodology nor readily available benchmarks on what services are too much, too little or simply adequate for a community's need. Certain questions are bound to arise in the community when hospitals close, merge, consolidate or eliminate services. Are there adequate medical/surgical, pediatric and obstetric beds in a market, given the age and sex distribution of the area's population? Is there adequate emergency/urgent/observation capacity? What, in fact, is adequate? Key aspects of access to care can also include linguistic barriers, outreach and education, and the ability of patients and physicians to exercise preferences for given services. Very few studies have systematically examined the effects of consolidation on a community's access to care. The availability of certain services to a community should be monitored in Massachusetts to ensure that access is not threatened in given markets.

Recently, legislators in Massachusetts filed a bill that would increase scrutiny of for-profit conversions of acute hospitals and HMOs. The legislation would require public hearings on the sale, continuance indefinitely of current levels of free care, terms prohibiting private benefit from the transaction and availability to the

Costs and Revenues Before and After Mergers

	Change in Cost per Case Mix Adjusted Discharge (CMAD)					Change in Net Revenue per CMAD
	FY91	FY92	FY93	FY94	FY95	FY95
Statewide	2.7 %	2.3 %	0.9 %	-0.5 %	0.9 %	-0.5 %
Metrowest		-4.0 %	4.0 %	1.2 %	-4.9 %	-5.5 %
Saints Memorial		-6.5 %	1.0 %	-3.1 %	4.3 %	N/A
Good Samaritan		3.5 %	7.4 %	-1.9 %	-4.0 %	-6.2 %
Health Alliance					3.5 %	-4.6 %

The white shaded area represents post-merger rates.

Figure 3

public of transaction-related documents. In addition to reviewing these issues, however, there is a need to consider the *overall statewide* changes that have occurred as a result of mergers, like changes in the levels of market-specific competition, the extent to which any realized savings are being passed on to purchasers, and changes in access.

Conclusion

The acute hospital industry has undergone tremendous restructuring over the last five years with mergers, acquisitions, closures, conversions and the development of integrated delivery systems accelerating nationally and here in Massachusetts. Antitrust scrutiny by federal and state agencies has come under fire, particularly in the for-profit conversion area. Lawmakers in Massachusetts have begun to shore up the regulatory agencies' roles in the antitrust arena through regulatory and legislative changes. The goal of these changes is to ensure continued access to care for the uninsured in the wake of for-profit conversions.

There is little evidence from formal studies that hospital consolidation brings efficiencies or the passing on of resultant savings to health care purchasers. In Massachusetts, there is some indication of savings from earlier mergers, and evidence of the contraction of overall capacity in response to market forces, but it is still too soon to assess the economic and access effects of more recent activity. There is, therefore, a need for continued statewide monitoring of the impact of consolidation on market concentration and competition and whether realized cost savings are translated into lower prices for purchasers.

Further Reading

[illegible]

Did you know?

Hospital Facts

	Massachusetts FY96	FY95**	FY94	FY93	US FY95	California FY95
Number of Hospitals						
Acute	79	83	87	89	5,194	424
Non-Acute	56	56	54	54	682	53
Number of Acute Hospitel Discherges (thousends)	750	785	823	881	30,945	3,029
Number of Acute Hospital Discharges/1,000 population	124*	130	137	147	117	94
Number of Acute Hospital Days/1,000 population	645*	698	766	873	756	511
Acute Hospital Length of Stay	5.2	5.38	5.68	5.97	6.5	5.4
Percent Inpetient Hospitel Revenues	N/A	61%	64%	67%	70%	74%
Percent Outpatient Hospital Revenues	N/A	39%	36%	33%	30%	26%

* Using 1995 population data ** Revised to reflect updated data

Most Frequent Hospital Stays, 1996

Reason for Stay (Diagnosis Related Group)	Total Discharges FY96	Average Length of Stay	Average Charges
Normal neonate end neonate with uncomplicated problems	71,094	2.25	$ 1,125
Vaginel delivery	60,042	2.19	$ 3,558
Psychoses	24,533	10.72	$ 9,970
Heert failure end shock	22,077	5.40	$ 7,435
Simple pneumonie end pleurisy	18,697	5.54	$ 7,137
Ceserean delivery	16,016	4.21	$ 6,716
Circulatory disorders with ecute myocardial infarction	14,915	5.62	$ 11,086
Chronic obstructive pulmonary disease	12,643	5.54	$ 6,875
Other digestive system diegnoses*	12,225	4.37	$ 6,478
Nutritional and miscelleneous metabolic disorders	11,587	4.77	$ 6,024

* All medical diagnoses other then digestive malignancy, G.I. hemorrhage & perforation, inflammatory bowel disease, G.I. obstruction, and nonbacterial gastroenteritis & abdominal pain. No surgical procedures included.

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FINANCING GRADUATE MEDICAL EDUCATION IN MASSACHUSETTS

Graduate medical education (GME) is a multi-billion dollar enterprise that provides a valuable product — trained physicians — to the nation. In 1996, the Congressional Budget Office estimated the costs of GME at over $6.7 billion dollars. Massachusetts hospitals' direct costs of training medical residents exceed $300 million per year. Recent developments in the health care system — discussions about savings in the Medicare program, competitive pressures brought by managed care and public policy changes — threaten the financing of GME in Massachusetts and throughout the nation. At the same time, there are calls to reduce the overall number of residents nationwide and to emphasize the training of primary care residents. This issue of *Healthpoint* examines policy implications concerning graduate medical education financing and what is at stake for institutions in Massachusetts.

Current Funding Sources

Graduate medical education involves the financing of physician residency, nursing and medical student training. This discussion will focus only on physician residency which comprises the bulk of GME expenditure. Graduate medical education is funded through various mechanisms. The largest source by far has been the federal Medicare program. Medicare reimburses health care institutions, mainly teaching hospitals but increasingly managed care organizations, for GME with an allowance built into its inpatient hospital payments. There is a direct payment for costs such as salaries and an indirect adjustment for associated costs of physician training. Massachusetts hospitals received $342 million for GME from Medicare in 1993 (most recent data available).

State funds, amounting to about $20 million per year, support GME via the Medicaid program, which includes an allowance for direct medical education costs only in its payments to hospitals. Teaching hospitals finance GME costs through charges to their privately insured patients. There are also research grants to which teaching hospitals have access; Massachusetts hospitals receive the highest share of National Institutes of Health (NIH) grant funds of any state in the nation.

GME as a "Public Good"

The financing of GME is justifiably broad-based, because graduate medical education is a "public good." It provides large volume physician services in teaching hospi-

Direct Spending for GME by Massachusetts Acute Hospitals
Fiscal Year 1996

Hospital	GME Costs ($ millions)	FTE Residents*
Brigham and Women's	$ 51.4	551
MGH	$ 48.5	544
Baystate	$ 31.2	234
Boston City[1]	$ 26.9	227
Cambridge	$ 18.8	39
Children's	$ 17.0	446
UMMC	$ 15.6	271
Deaconess[2]	$ 15.2	162
NEMC	$ 15.2	334
BUMC	$ 12.5	152
All hospitals	*$ 336.5*	*4241*

*Full time equivalent intern, resident and fellow positions reported by hospital

[1]Merged with BUMC
[2]Merged with Beth Israel ($8.0m, 288 FTE)

Source: DHCFP-403

Table 1

tals which often disproportionately bear the burden of providing care for the indigent. Five teaching hospitals participating in GME in Massachusetts — Boston Medical Center, Cambridge Hospital, Brigham & Women's, Massachusetts General and Bay State Medical Center — provide the lion's share of uncompensated care to the uninsured and underinsured in Massachusetts. GME payments to teaching hospitals also help to maintain the availability of high quality specialty care, such as endocrinology, neurosurgery, cardiac surgery and orthopedic surgery, for state residents.

GME funding provides for the training of most future clinicians for whom residency is the bridge to a clinical career. Also, residents and fellows often conduct medical research funded by GME dollars. This research sometimes results in path-breaking mechanisms of prevention, treatment and management of disease. These social benefits to which GME contributes warrant broad sharing of GME costs, rather than assigning those costs to a single, narrow source, whether public or private.

The Changing Demographics of Residents

Trends in the physician workforce invite policy action that might include reduced GME funding for certain residents. In February, the American Medical Association, the Association of American Medical Colleges, other professional and academic medical associations issued the *Consensus Statement on the Physician Workforce,* which identified an oversupply of physicians overall, with a shortage in some geographic areas and specialties. There is currently a growing need for more primary care and family practice physicians in this managed care era. The Massachusetts Medicaid program recognizes this by reimbursing hospitals more for primary care residencies than for specialties.

Massachusetts has the second highest ratio of physicians to population in the country. In addition, the state is among the top 10 states in the number of international medical graduates (IMGs) in its residency programs. Many IMGs fill a need during their residencies by providing care in underserved areas, a major element of teaching hospitals' public mission. But the general surplus of physicians and the pressure to reduce Medicare spending put IMGs in jeopardy because financing the residencies of foreign medical school graduates, who may specialize further or not stay to practice in the community, can be seen as less in keeping with long-term state healthcare workforce needs. Massachusetts hospitals are therefore vulnerable to cuts in funding for IMGs. As this debate proceeds, however, it should be noted that fully 44 percent of IMGs nationally are US citizens or permanent residents.

Policy Challenges for Financing GME

A number of factors in the health care environment pose threats to the current system of financing medical education. One challenge lies with federal GME financing. Current proposals suggest cuts of over $100 billion in proposed Medicare spending by 2000, which would create a significant gap in GME funding.

Other challenges lie within teaching hospitals. Hospital admissions, patient revenues and research dollars are slowing or declining. Teaching hospitals are being asked to look for alternative and innovative ways to finance their teaching responsibilities in a health care environment that is demanding that residents be trained in primary care settings where the dollars are sparse. Private payers, under pressure to control *their* costs, are shifting their business to less expensive sites of care since teaching hospital costs are typically higher than those of non-teaching hospitals. These shifts make fewer resources available for GME at the hospital level. The research grant pool is also diminishing relative to research costs.

Managed Care and GME

Finally, a challenge lies with managed care organizations (MCOs), both as a source of funds and a source for care. Managed care currently accounts for over 50 percent of private group health insurance in Massachusetts. As payers, MCOs, with their market strength and reputation for cost control, exert downward pressure on hospital revenues which, for teaching hospitals, include funds used for GME.

Managed care plans have also entered the competition for receiving Medicare payments as they enroll Medicare clients in senior HMOs. These payments — a fixed fee per member — are calculated as a percentage of the average fee-for-service Medicare payment in an area, and implicitly include the proportion for residency training and services that is part of Medicare rates. The question of whether this portion of Medicare dollars actually gets into the GME funding stream — either in the form of payments to hospitals or through the direct training of physicians — is a subject of debate. Fewer than 15 percent of HMOs nationwide participate directly in graduate medical education.

Some MCOs in Massachusetts are experimenting with putting a medical school department within the confines of their MCO sites. Such a model has been promoted as potentially able to transform academic medicine from being clinically based to being more community oriented, with an emphasis on training primary care physicians. The question remains whether this will be a more cost-effective way to train residents, whether the quality of resident training will be upheld or improved, and whether ambulatory care sites that are being asked to train residents will become overburdened.

Current Policy Proposals

Because of its wide social benefits, there is general agreement that all stakeholders — teaching and non-teaching hospitals, private insurers, employers and government — should share in the social cost of graduate medical education. Cuts in GME funding from the federal government seem inevitable; public dollars will still be needed to support GME since private sector dollars alone will be unable to sustain it.

The idea of a trust fund, where a common pool of resources independent of the reimbursement for care is garnered from hospitals and insurers, has been a constant feature of recent proposals. The Institute of Medicine supports the replacement of the current Medicare funding of GME with a Na-

Residents and IMGs by State
1995

State	Residents	Residents per 100,000 population	IMGs as % of of total residents*
NY	14,937	83	44%
CA	8,678	29	12%
PA	6,585	55	23%
TX	6,032	36	17%
IL	5,415	47	35%
OH	4,763	44	21%
MA	*4,345*	*72*	*21%*
FL	2,617	20	19%
DC	1,693	279	20%

Data are for 1993-94

Sources: JAMA September 6, 1995, Vol. 274, No.9; AAMC Data Book, Table F-11.12

Table 2

tional Graduate Medical Education Trust Fund. Other suggested non-Medicare sources of revenue include the general tax base or a special tax. In Massachusetts, a bill (H. 1099) that calls for a similar trust fund was introduced in this session but is unlikely to pass.

Next to society as a whole, teaching hospitals — and their public mission of training, research and indigent care — are most at risk if GME funding is severely restricted. They are therefore trying to be more creative in supporting GME. Many are looking to private sources such as foundations or pharmaceutical, biomedical and biotechnological companies for academic research dollars.

New York State, which trains about 15 percent of the nation's residents, has begun a six year pilot program with approval from the Health Care Financing Administration (HCFA). This program aims to eliminate existing incentives that cause hospitals to maintain or expand their residency slots even when there is a probable oversupply of physicians and health service delivery is shifting to ambulatory settings. Participating institutions agree to reduce their residents by 20 to 25 percent over five years. To cushion the financial blow of lost Medicare GME payments, HCFA will provide funding that will maintain financing at current levels in the first year and gradually reduce payments over the next six. Over the long run, the program will save money for Medicare and, because of New York's position as the preeminent state for GME, will help reverse a growing oversupply of physicians.

HCFA recently opened this program to Massachusetts hospitals as well, but they have declined to participate, calling for a national program to address physician oversupply instead. Many teaching hospitals in the state have already begun to reduce the number of residencies on their own; participation in the HCFA pilot would be seen as an additional financial hardship.

Future Directions

Graduate medical education presents a set of complicated policy issues within an already complicated system of financing and delivering health care. To understand the issues more completely, further study of the costs and benefits of residency programs and their funding sources, as well as an understanding of physician supply needs across the state, would be beneficial. At the center of it all are the residents, who need to be trained with skills that will serve the public and thrive in the managed care environment. Policy makers should consider alternative sources and mechanisms of GME funding to replace the possible loss of federal funds, as well as how to link GME financing to physician workforce needs. Finally, GME reformers must look at the future of the Commonwealth's teaching hospitals which — in addition to being sites of valuable training, research, specialty and indigent care — are important engines of the economy.

Further Reading

1. ...ournal of the American Medical Association ... 276, No. 9 (September 4, 1996).
...tement of the Institute of Medicine on the Nation's Physician Workforce Projections for Balancing Supply and Requirements before the Sub...mittee on Health, Committee on Ways and Means, US House of Representatives, April 6, 1996.
...he Bureau of National Affairs, *Health Care Policy Report*, vol. 5, No. 8 (February 24, 1997).

Did you know?

If you would like to obtain additional copies of this issue or back issues, please contact Dorothy Barron at (617) 451-5330. Topics featured in past issues of *Healthpoint*:

Hospital Mergers and the Public Interest, Volume 2, Number 3
Mandated Benefits, Volume 2, Number 2
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HEALTH CARE IN THE INFORMATION AGE: PROTECTING PRIVACY AND INFORMATION

Information or privacy? The debate over collection and use of personally identifiable health data has focused on a trade-off between the two. "Health data" means records of an individual's medical care as well as general information such as gender, age, area of residence, and insurer. Clinical information may include a medical history, details about lifestyle (smoking, alcohol intake, risk behaviors), and treatment history. Though paper records are not immune from mishandling, the increased computerization of this personal information has raised public anxiety. Privacy advocates and patients are concerned that sensitive information, such as identifiable medical records, may now be accessed instantly and shared widely over computer networks. This issue of *Healthpoint* looks at the many uses of health data, considers the privacy concerns over database technology and access to information, and highlights existing and proposed policies that are designed to preserve both data and privacy, rather than one over the other.

Health Data Uses & Benefits

The information collected from an individual's visits to a primary care provider, specialist or hospital is used most often in treatment decisions. Increasingly, it is also used by other health care-related entities for non-clinical purposes. Insurers may use the information, with identifiers, to determine payment for clinical services. When multiple cases are aggregated, health data offer researchers insight into health concerns of specific populations — not individual patients — and provide information for quality of care and cost containment initiatives. The resulting products — epidemiological studies, information on the use of health care services, and the like — are often used by public officials to shape public policy or by health care providers to improve delivery of services.

Health data have been collected and used for public health purposes for hundreds of years. As early as 1741, tavern keepers in Rhode Island were instructed to report patrons with contagious diseases to local authorities. National mortality statistics were first published in 1850. The eradication of smallpox in the early twentieth century was made possible through collection of information on persons with the disease and vaccination of those who may have been exposed. More recent efforts, such as public health campaigns around smoking cessation and cancer screening, all rely on health data to target their messages. This type of close and continuous observation and investigation

into a population's health helps policy makers allocate resources and focus interventions in areas with the greatest need.

Aggregate health data are also used by public policy analysts to evaluate, for example, services for underserved populations, or by employers to compare managed care plans with which they contract. Public agencies, like the state Division of Health Care Finance and Policy and Department of Public Health, and the federal Health Care Financing Administration and Agency for Health Care Policy and Research, publish reports that health care systems put to use in promoting the efficient use of resources and improving the quality of clinical care. These and other agencies are also sources of data for health services researchers, whose disinterested, academically rigorous work benefits health systems and the public's health.

Privacy Concerns

When in the wrong hands or used by the wrong persons, this "benevolent" information can have harmful repercussions. In Tampa, Florida for example, a public health employee released a list of identifiable HIV patients to a newspaper reporter. If health data identifies patients, as it must in its original state, protecting data access and patients' privacy become critical. In addition to the violation of an individual's right to privacy by the improper disclosure of information, the improper *use* of even appropriately held data could result in discrimination by employers and insurers.

Additional privacy concerns surround the Health Insurance Portability and Accountability Act (HIPAA) of 1996, which provides for portability of health insurance, the electronic transfer of data, and development of a unique patient identifier to facilitate data transfers to achieve administrative savings. Linking medical information with life-long personal identifiers raises issues about collection, use and distribution of these data. HIPAA required the executive branch to study means to protect privacy and to make policy recommendations (see "Federal and State Action" below).

Privacy Safeguards

The National Library of Medicine, an executive branch agency with a lead role in facilitating health care applications of the "national information infrastructure," commissioned the Computer Science and Technology Board (CTSB) of the National Research Council to study health data privacy issues. The CTSB's recommendations are detailed in *For the Record: Protecting Electronic Health Information* (National Academy Press, 1997), and include provisions for:

Technical Practices

- Individual authentication of users
- Access controls
- Audit trails
- Physical security and disaster recovery
- Protection of remote access points
- Protection of external electronic communications

Organizational Practices

- Security and confidentiality policies
- Security and confidentiality committees
- Information security officers
- Education and training programs
- Sanctions
- Improved authorization forms
- Patient access to audit logs

Safeguards

Keeping records on paper and in physical files seems comfortable to many people, but it is not without its hazards. Though newer technology can be threatening, it also offers ways, previously unavailable, to protect privacy. For example, data *encryption*, where complex algorithms encode personal identifiers before data are shared, protects the confidentiality of individuals; with traditional paper records, the difficulties of creating non-identifiable data are significant. Electronic *firewalls* within computer systems protect against unauthorized outsiders obtaining information, and *audit trails* allow a systems operator to know who has accessed information and helps determine if there has

been a breach of security. With paper medical records, it is more difficult to be sure that no unauthorized person had accessed the record. Requirements for passwords to access information, along with penalties for sharing pass codes or for improperly disclosing information, can also be effective.

As with the case in Tampa, however, the problem is often human, not technological. Stringent technological protections, accompanied by strong organizational ones, are the best we can do to keep prying eyes away, if medical records are to exist at all.

Summary of Recommendations by HHS Secretary Donna E. Shalala (September 11, 1997)

Boundaries. Use health care information for health purposes only (with a few exceptions) and include all health care providers, payers and service organizations, such as claims processors and pharmacies, under rules governing disclosure.

Security. Prohibit disclosure of patient-identifiable information except when authorized by the patient or as explicitly permitted by legislation, and require those holding information to implement security measures. Prohibit employers acting as payers from using health information for personnel decisions.

Consumer Control. Require providers and payers to inform patients in writing of their information practices, including access, storage, and patients' rights to limit access, authorize disclosure, and see, copy and correct records.

Accountability. Impose criminal penalties for violation of standards, higher when violations are for monetary gain. Permit individuals whose rights have been violated to bring action for damages.

Public Responsibility. Permit limited disclosures of information without patient consent, but with strong protections, for specific national priority activities, including:

- Oversight of the health care system
- Public health
- Health research (including state health data systems)
- Law enforcement

Federal law should provide a minimum standard and should not preempt more stringent state laws.

Federal and State Action

State and federal governments recognize the need for safeguards. In Massachusetts, for example, the Fair Information Practices Act (FIPA) of 1975 protects personal data, and specifically medical data, when the disclosure of such data may constitute an unwarranted invasion of personal privacy. The statute requires security measures — covering accountability, physical security, control of disclosure, and more — to be enacted and enforced by agencies that collect, use, maintain or disseminate personal data for governmental or public functions.

FIPA also provides for penalties for violation of any of its protections, including payment of actual damages, exemplary damages and attorneys' fees. FIPA, the Code of Conduct of the Commonwealth (MGL c. 268A, §23), and many other individual department regulations, policies and procedures protect the privacy of health data. The Executive Office of Health and Human Services is currently reevaluating the scope and effectiveness of these laws and regulations in the agencies under its authority, in the context of its work with the legislative committee considering comprehensive legislation regulating the disclosure of medical records.

Federal policy makers have conducted their own reevaluation. The Health Insurance Portability and Accountability Act of 1996 asked the Secretary of Health and Human Services to recommend federal legislation for the protection of the privacy of individually identifiable health information. To advise the Secretary, the National Committee on Vital and Health Statistics (NCVHS) subcommittee on Privacy and Confidentiality held hearings between January and June 1997, at which 47 experts from public and private organizations testified. The committee considered methods of technological protection, patient access to and amendment of information, authorizations and limitations of disclosure, usefulness of health research, public health, law enforcement, and other issues. HHS Secretary Shalala delivered her recommendations, based largely on the NCVHS report, to Congress on September 11 (see shaded box above).

Decisions

Forty-eight states have laws regarding heath data and privacy protection; new legislation is pending in Massachusetts and other states. Currently, rules such as those in FIPA, the Code of Conduct for Commonwealth employees and individual agency policies provide a basic standard for data security and integrity. While these rules address public agencies, data security standards differ among public and private organizations (physicians, hospitals, health plans, insurers and others). Current levels of security vary, but federal regulations under HIPAA should provide a standard. Such a standard should consider the many uses of data and the appropriate degree of access associated with each use, and protect the data with a combination of encryption and other safeguards, monitoring, and financial and criminal penalties.

That health data can be used for beneficial purposes is beyond dispute. When it is sensitive and accessible, security and privacy concerns are very real. But thoughtful policy measures and security standards that recognize both the risks and benefits of access to data can counter these threats. By understanding the safeguards that are in place, requiring the technical security that computers can provide, being mindful of federal action and making new state policy when necessary, Massachusetts policy makers can create an environment that effects the proper balance between protecting the individual and promoting worthwhile uses of health data.

Further Reading

Fact Sheet # 8 *How Private Is My Medical Information?* [illegible] San Diego [illegible]

2 *For the Record: Protecting Electronic Health Information* [illegible] National Research Council Washington DC National Academy Press 1997

3 *Institute of Medicine. Health Data in the Information Age: Use, Disclosure and Privacy.* Washington DC National Academy Press 1994

4 *Testimony of Donna E. Shalala, Secretary, United States Department of Health and Human Services.* September [illegible] (http://aspe.os.dhhs.gov/admnsimp/)

Did you know?

Preventable Hospitalizations by Diagnosis

	All Ages						*Ages 0-64*					
	Discharges		Total Charges ($millions)		Share of Total Discharges		Discharges		Total Charges ($millions)		Share of Total Discharges	
Diagnostic Group	FY92	FY96	FY92	FY96	FY92	FY96	FY92	FY96	FY92	FY96	FY92	FY96
All PH Conditions	137,328	108,897	838.8	764.5	15%	14%	61,736	43,628	303.0	273.4	10%	9%
Congestive Heart Failure	24,406	23,756	194.7	192.0	3%	3%	3,933	3,595	31.8	31.9	1%	1%
Bacterial Pneumonia	21,115	20,067	162.8	166.7	2%	3%	7,807	6,900	51.2	53.9	1%	1%
Angina	16,787	5,259	65.8	21.7	2%	1%	6,001	1,983	21.1	7.7	1%	0%
Asthma	13,449	9,030	57.9	47.0	1%	1%	10,731	7,368	38.5	35.2	2%	2%
Dehydration	10,351	8,805	56.9	51.1	1%	1%	4,881	3,515	18.1	16.5	1%	1%

* Preventable hospitalizations (PHs) are hospitalizations for ambulatory care sensitive conditions than can be reduced through the timely use of primary health care services. They serve to identify potential barriers to the delivery and/or utilization of more cost-effective primary care services. Total PH figures between tables may not be consistent due to coding errors.

Preventable Hospitalizations by Payer, All Ages—1996

Payer Group	Discharges	Total Charges ($Millions)	Share of Total PH Discharges
All Payers	108,316	764.3	100%
Medicare	64,408	502.5	59%
Medicaid	9,413	64.5	9%
HMOs	11,136	65.2	10%
Blue Cross	8,447	56.1	8%
Commercial Insurers	4,977	29.5	5%
Uninsured	5,242	30.8	5%
Other	4,693	15.7	4%

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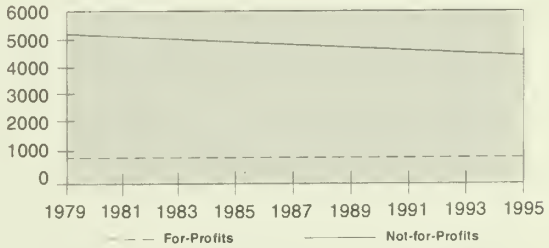
DOES HOSPITAL OWNERSHIP MATTER?

Since Columbia/HCA, the nation's largest for-profit health care corporation, took over Metrowest Medical Center in 1996, the conversion of not-for-profit hospitals to for-profit facilities has provoked strong debate in Massachusetts. The policy debate reached its most vocal level with the proposed sale of Neponset Valley Health System to Columbia/HCA. Public opposition to the acquisition prompted the introduction of legislation to halt future transfers until further review of the social and economic impacts. Laws to regulate the transfer of hospital assets from community boards to for-profit entities are under consideration throughout the country. Rhode Island and New Hampshire have already passed such legislation. This issue of *Healthpoint* provides a context for thinking about hospital conversions, examines the extent of for-profit ownership in Massachusetts, discusses the specific issues surrounding hospital asset transfers, and highlights existing and proposed policies designed to manage the conversion process.

Are We Missing the Forest for the Trees?

Investors seeking profits is only one feature of a hospital industry that has undergone profound change over the past two decades. Fifteen years ago, hospitals controlled the terms of inpatient care, deciding the level of services patients received and being reimbursed their full costs. In 1983, Medicare replaced cost-based payment with a set of prices based on diagnosis, releasing a flood of competitive pressures. Many laws regulating hospitals have been rescinded, giving other payers freedom to arrange independent contracts. Managed care organizations have become major players, negotiating lower hospital rates. Independent physician practices have begun to consolidate, strengthening their leverage in hospital contract negotiations. Many hospitals have entered affiliations, creating competitive advantages through lower unit costs. As a result of all this, many nonprofit hospitals face financial uncertainty.

Figure 1: Number of U.S. Hospitals by Ownership



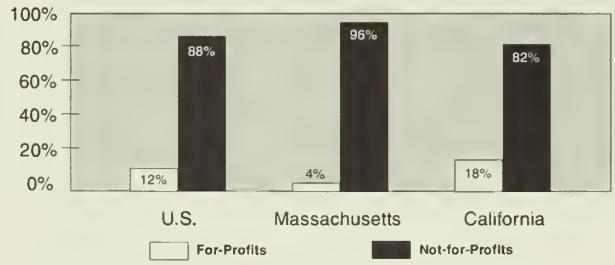
Note: Not-for-profit hospitals include state and local government facilities.
Source: *1996/97 Hospital Statistics*, AHA

These growing competitive pressures blur many of the traditional distinctions between profit and not-for-profit facilities. Profit-oriented practices —reducing and downgrading patient care staffing, eliminating unprofitable services and undertaking marketing and other promotional activities, for example — are reportedly being adopted by non-profits. Competition may also affect hospitals' traditional function of providing indigent care. In today's market, hospitals may be less able to perform this task without exposing themselves to further financial risk. This depends less on whether or not they are profit-making than on the extent and sources of price competition in their market.

What's the Reality in Massachusetts Today?

The perception of widespread hospital conversions does not match the reality. For-profit facilities represent a fraction of all community hospitals in the US.[1] According to the American Hospital Association's latest survey, 15 percent of hospitals were investor-owned in 1995, accounting for 12 percent of hospital beds and 11 percent of admissions (see Figure 1 on page 1). Historically, investor-owned hospitals played a much larger role. In the early 1900s, over half of all hospitals were run by doctors on a for-profit basis (though, admittedly, they looked very different from today's corporations). By the end of WWII, their share had dropped to below 20 percent, and has remained there ever since.

Figure 2: 1995 Share of Hospital Beds by Ownership



Note: Not-for-profit hospitals include state and local government facilities.
Source: *1996/97 Hospital Statistics*, AHA

For-profit hospitals are even less prevalent in Massachusetts. According to AHA data, six percent of the state's hospitals were owned by for-profit companies in 1995, compared with 25 percent in California. Investor-owned facilities in Massachusetts controlled four percent of hospital beds and two percent of admissions (see Figure 2 left).

Despite the small share of for-profit hospitals in Massachusetts, the importance of investor-owned conversions should not be ignored. First, for-profit chains may continue expanding their presence in the State. In 1993 and 1994, two hospitals were bought by for-profit chains. (See Figure 3 below). By 1997, two more hospitals had been converted, with two offers under review. (One of these offers has been rescinded.) Since many of the basic management decisions of for-profits get made by executives who reside outside of the region and are based on the short-run interests of shareholders, further conversions in the state raise concerns about the ability of hospitals to continue meeting their social obligations. The second reason hospital ownership is an important policy issue is that the establishment of a few investor-owned facilities can have an enormous impact on the practice styles of non-profits. For-profits introduce greater competition, forcing all hospitals in the market to adopt "profit-based" management strategies.

Figure 3: For-Profit Hospitals in Massachusetts, 1997

Hospital	Owner	Status
Breintree Hospital	Healthsouth	completed
Fairlewn Rehabilitetion Hospital	Heelthsouth	completed
New England Rehab. Hosp.	Healthsouth	completed
Whittier Rehabilitation Hospital	Individuelly owned	completed
JB Thomas (THC-Boston)	Transitional	completed
Hahnemenn (Vencor Hospital)	Vencor	completed
Metrowest Medical Center	Columbia/HCA	completed
St. Vincent's Health Care System	Tenet	completed
Boston Regional Medical Center	Doctors' Corp. of America	pending
Neponset Valley Health System	Columbia/HCA	canceled

Note: Rehabilitation facilities included in this table meet the AHA's criterion of average lengths of stay less than 30 days. In addition to for-profit "community" hospitals, the 1997 AHA Guide identifies 13 "non-community" investor-owned facilities in Massachusetts, including ten psychiatric, two substance abuse and one rehabilitation (with an average length of stay longer than 30 days).

What Are the Issues?

There are four broad categories of issues that policy makers should consider when a hospital proposes a change in ownership.

Short-run financial imperatives. In today's competitive market, many hospitals are unable to repay the huge debts accumulated during the expansionary periods of the 1970s and 1980s. A survey by Project Hope of ten converted hospitals around the country reported that several facilities would have been forced to close without the access to capital markets offered by for-profit companies.[2] Hospitals claimed they had no choice but to consider for-profit over nonprofit affiliations because only the former provided debt repayment. An analysis of all hospital conversions between 1988 and 1995 confirmed that, before conversion, the facilities were in relatively poor financial shape.

Long-run economic sustainability. Project Hope's survey reported that several hospitals converted because their boards believed they would be unable to survive as an independent facility given the consolidation and increased managed care penetration in their markets. Hospital administrators claimed that merging with a larger investor-owned chain offered the best opportunity to build networks of providers, increase leverage with third party payers, and exploit efficiencies in scale and scope.

The impact of ownership on efficiency is unresolved. A 1997 Harvard Medical School study found greater shares of administrative costs and higher per-patient costs in for-profits. A 1997 study by the Voluntary Hospital Association (VHA) of six hospital markets in Florida found that purported cost savings in for-profits were achieved through lower patient care staffing. Other studies, however, conclude that for-profits are more efficient than not-for-profits (Ferrier and Valdmanis, 1996).

Quality and access. One concern surrounding conversions is that the profit motive will impel hospitals to lower quality of care. Even when quality remains unaffected, communities fear that converted hospitals will select healthier, more profitable patients, while discouraging the admission of the severely or chronically ill. One way of doing this is by eliminating unprofitable services in such areas as trauma care, mental health and obstetrics.

The evidence on differences in quality and access between for-profits and non-profits is also equivocal. Shortell and Hughes (1988) and Kuhn et al. (1994) found no difference in mortality rates between the two types of institutions. Mann et al. (1995) state anecdotally that more than half of the converted hospitals in Southern California once belonging to a trauma care network downgraded their emergency rooms, no longer designating them trauma centers. A recent study of inpatient psychiatric services (Schlesinger, et al., 1997) found non-profits provided greater access in terms of availability of services and provision of uncompensated care.

Community benefits. In exchange for their tax-exempt status, nonprofit hospitals have assumed the role of providing many of the community benefits of health care, such as the provision of indigent care, unprofitable services, health care research and education, and public health services like immunizations and screenings. Here again, the evidence of whether for-profits provide fewer social goods is inconclusive. Young et al. (1997) and Norton and Staiger (1994) conclude that, when for-profits and not-for-profits are located in the same area, they serve an equal number of uninsured patients. In contrast, other studies found that for-profits provided less free care, research and education than their nonprofit counterparts (Mann et al. [1995], VHA [1997]).

In sum, legislators wishing to protect the community benefits of health care must address the full range of financial and economic realities facing hospitals in today's competitive market. Simply placing a moratorium on future conversions maintains existing inefficiencies in the hospital sector and puts many stand-alone facilities at a competitive disadvantage. On the other hand, policy mak-

ers ought to ensure that when hospitals do convert to for-profit entities, access and quality are not adversely affected by the transfer and all charitable assets remain available for continued public use.

What Should We Be Doing?

State responsibility for approving hospital conversions lies with the Attorney General (AG) and the Department of Public Health (DPH). The AG sees that conversions do not violate antitrust laws and assets continue to fulfill charitable obligations. DPH ensures that community benefits are considered when issuing hospital licenses. Final licensure decision rests with the Public Health Council only after a public hearing gives interested parties the opportunity to voice their concerns.

A wide variety of tools have been used to manage hospital conversions. Guidelines cover such areas as providing for open public discussion and information prior to conversion, securing commitments regarding service levels and community benefits, establishing autonomous control of and reporting on charitable assets, prohibiting financial gain by employees or trustees of a nonprofit entity, and limiting the speed and the extent of for-profit expansion. Policy makers may also consider initiatives that shift some of the burden of free care away from hospitals. Steps in this direction already being taken include expanding health insurance coverage for low income people and using the uncompensated care pool to finance preventive health services among the uninsured.

Not only is it too soon to draw firm conclusions from the data, but such a narrow focus detracts from the larger issue of the impact of increased price competition on all hospitals. This report was intended to provide a framework for thinking about conversions and about public policies to manage future transfers. Competition creates opportunities to realize efficiencies in the provision of health care services, as well as challenges to develop new ways of fulfilling the social obligations. There is no reason why hospital conversions cannot be designed in a way that contributes to both of these aims.

Endnotes

Further Reading

Did you know?

Massachusetts HMO Spending and Utilization, 1995

Spending, Per Member Per Month	Low	Median	High
Total	$ 123.19	$ 145.82	$ 160.31
Non-medical	$ 13.13	$ 20.07	$ 28.00
Medical	$ 106.07	$ 127.52	$ 137.07
Inpatient Facility	$ 22.00	$ 27.22	$ 34.78
Pharmacy	$ 8.23	$ 11.61	$ 16.63
Ambulatory Surgery	$ 3.99	$ 6.37	$ 10.82
Emergency Room	$ 0.50	$ 2.83	$ 4.63
Professional and Other	$ 60.04	$ 74.66	$ 95.16
Utilization, Per 1,000 Members	**Low**	**Median**	**High**
Medical/Surgical Inpatient Days	128	151	229
Ambulatory Surgery Visits	40	63	108
Emgency Room Visits	96	138	276

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HOME HEALTH: AN EMERGING CHALLENGE IN HEALTH CARE

Home health is one of the fastest growing areas in health care. Nationally, total home health expenditures more than doubled from 1990 to 1996 (from $13.1 to $30.2 billion), mostly from Medicare and Medicaid. In contrast, nursing home expenditures increased by 54% (to $78.5 billion), and hospital care expenditures by 40% (to $358.5 billion).[1] Among the main drivers of rapid growth in home health are shorter lengths of hospital stays, a shift toward less expensive care sites and patient preference for treatment and support in home and community settings.

The rapid expansion in home health care challenges policy makers to balance two objectives—control public spending and ensure access to quality care. The Health Care Financing Administration (HCFA) is developing a new payment system for Medicare home health services to discourage fraud, promote quality and control spending. In the absence of information systems on structure and outcomes of home health, we can make only educated assumptions about the effects of a new reimbursement system on home health care. Past experience, however, suggests that changes in one area may produce some unintended effects throughout the system.

The impending changes in Medicare home health reimbursement have important implications for Massachusetts. This issue of *Healthpoint* discusses recent trends and policy changes, and highlights implications for home health providers, recipients and policy makers. The upcoming changes will be dramatic, and may affect the structure and financial health of home health agencies, and the quality of the care they deliver.

What Constitutes Home Health Care?

Home health care is provided to individuals in their place of residence to promote, maintain, or restore health or to maximize independence while minimizing the effects of disability and illness. Currently, all homebound elderly and disabled Medicare beneficiaries are eligible for free unlimited visits prescribed by a physician; Medicaid and private insurers cover these services as well. Home health services range from high-intensity skilled nursing care to lower-intensity, custodial services such as assistance in bathing and eating. These services are grouped into six broad categories: skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, and medical social work. In Massachusetts, Medicaid reimburses home health agencies for all services except medical social work. Massachusetts Medicaid home health utilization data available for the three most recent years are shown in Figure 1 on page 2.

Recent Statistics

The 1994 National Home and Hospice Care Survey reported 9,800 agencies providing home health services in the United States.[2] Nearly three-quarters of the 3.6 million consumers of home health services in 1996 were elderly (age 65 and over) and about two-thirds were female.[3]

Public expenditure on home health has grown tremendously in the past decade. While most private insurers and HMOs cover home health care, Medicare is the largest purchaser of home health services and its share of total expenditures has grown over the last few years. National Medicare spending for home health services exceeded $17 billion in 1995 compared to $1.8 billion in 1987. Medicaid spending on home and community-based services more than quadrupled during the same period, totaling $9.7 billion in 1995 compared to $2.1 billion in 1987 (see Figure 2 on page 3).[4]

In Massachusetts, Medicare spent about $629 million for home health care in 1995 and Medicaid, about $125 million. Massachusetts ranked eighth highest in Medicare home health spending per enrollee, and fourth highest in Medicaid spending. In 1993, Massachusetts was among only ten states where both Medicare and Medicaid spending per enrollee exceeded national medians.[5]

Current Issues in Home Health Care

HCFA recently launched two initiatives to revamp home health care—Operation Restore Trust to reduce fraud and abuse; and the National Home Health Agency Prospective Payment Demonstration Project with an intent to eliminate fraud and abuse, to control growth in expenditure and to improve the quality of home health services. With Medicare paying for such a large portion of services, changes in Medicare policy will have a great impact on the home health industry overall.

Fraud and Abuse. Overbilling for services has been a major issue in home health. Operation Restore Trust (ORT), a two-year investigation by the U.S. Department of Health and Human Services in 1993-94, reported massive fraud and waste in Medicare billings in the five states studied: California, New York, Florida, Texas and Illinois. The "problem" agencies tended to be for-profit, closely held corporations with owners who were involved in interlocking, self-referring businesses.

In a 1997 audit in Massachusetts, HCFA found some overpayments but no cases of fraud. In an effort to prevent fraud in the state, the Attorney General has proposed licensing people who provide home health care, and establishing consumer protections. The Governor has also filed legislation requiring licensure of home health agencies and creating a registry of abusive workers. Currently, the Department of Public Health maintains a registry of fraud and abuse by nursing home workers.

Prospective Payment System. The revelations of ORT occurred just when Congress was looking for ways to control Medicare spending. Congress wanted to switch to a prospective payment system analogous to the one that Medicare now uses to pay hospitals. "Prospective payment" is a system in which a price is set for a certain type and amount of care and the provider is paid that price regardless of the resources needed to provide the services. While the provider is exposed to some financial risk in providing the service, the system also offers them financial rewards incentives for providing services at lower costs.

Historically, HCFA has used cost-based reimbursement for home health services. Cost based reimbursement offers providers few incentives for cost-

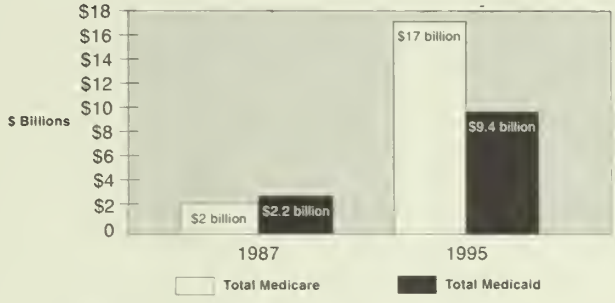
Figure 1: Medicaid Home Health Utilization in Massachusetts

	FY94		FY95		FY96	
Number of Agencies	128		152		167	
Service	Number of Visits	Costs (millions)	Number of Visits	Costs (millions)	Number of Visits	Costs (millions)
Nursing Care	622,399	$34.8	690,457	$38.8	719,206	$40.5
Home Health Aide	2,339,301*	$43.8	2,482,370*	$46.7	2,370,081	$44.6
Physical Therapy	69,475	$3.7	74,320	$4.2	75,631	$4.2
Speech Therapy	26,689	$1.6	27,647	$1.7	26,148	$1.6
Occupational Therapy	24,309	$1.4	25,276	$1.5	24,890	$1.5
Total	3,082,173	$85.5	3,300,070	$92.8	3,215,956	$92.4

* Home health aide services are measures in terms of hours.
Note: This table includes those agencies which filed Medicaid claims.
Source: Massachusetts Division of Health Care Finance and Policy

conscious behavior and, as substantiated by the findings of ORT, allows room for fraudulent practices. In the Balanced Budget Act of 1997, Congress created an interim payment system (IPS), freezing Medicare reimbursement at the 1993-94 rates before ORT began, with provisions for annual revisions for market inflation and patient case mix. It requires home health agencies to secure surety bonds of at least $50,000 to be eligible to provide home health services under the Medicare and Medicaid programs. Both of these IPS provisions impose economic strain on relatively low-cost, non-profit agencies like many of those in Massachusetts. The IPS will be in place until October 1, 1999, as HCFA moves toward prospective payment.

Figure 2: Growth in Federal Spending on Home Health



Source: Genevieve Kenney, et al. *Health Affairs*, Volume 17, Issue 1, 1998, p. 201-212.[4]

The HCFA demonstration project to test the extent to which prospective rate setting increases efficiency of Medicare home health care is now in its third and final year. Ninety-one agencies, including 11 in Massachusetts, are participating. If this system is adopted permanently, reimbursement rates, based on findings from the demonstration, would be set prospectively for a 120-day episode of care, irrespective of the number of visits and services per visit provided by an agency.

At this stage, it is unclear whether Medicaid would adopt the Medicare prospective payment system. Currently in Massachusetts, Medicaid pays home health agencies at a class rate for each service provided, with an add-on for certain high-volume providers.

Inequities in the System. The cost-based reimbursement system is inequitable in that it pays low-cost, efficient providers less than potentially inefficient high-cost providers. Agencies in Massachusetts provide care for relatively low average payments per visit and per patient. According to 1995 HCFA data, the average payment per visit was $50, compared to a national average of $62. The $4,730 average payment per patient was slightly above the national average of $4,473; but much lower than the $7,217 in Texas.[6] Because prospective rates would be determined based on historical costs, Massachusetts providers are likely to face this inequity even under the new system. To the extent that this imbalance reflects waste and inefficiency rather than true cost differences, should prospective rates be based on something other than historical costs?

Disparities also exist between Medicare and Medicaid reimbursement rates. For example, Medicare pays Massachusetts providers between $93 and $117 per skilled nursing visit, while Medicaid pays about $57. These differences create incentives for providers to maximize Medicare reimbursement to augment their revenues. If prospective payment threatens revenues by reducing the financial benefit of this "cost-shifting," providers' attention may turn more forcefully to reimbursement from other payment sources, particularly Medicaid. Further, changes in Medicare coverage mandated by the Balanced Budget Act may place additional pressure on Medicaid. Federal changes in Medicare payment practices may therefore raise important policy issues at the state level.

Performance Monitoring. Cost containment efforts raise concerns about access to quality care. Under prospective payment, providers may be impelled to provide fewer services for a set rate per episode, or to avoid patients needing high-intensity services. Consequently, more patients may need to use nursing home care which is more expensive, both for the system as a whole and for Medicaid. While the prospective payment system may reduce waste, it may also jeopardize the quality of care. Monitoring access to and quality of home health care therefore assumes greater significance, especially when only a limited and fragmented information system exists for home health.

HCFA has sponsored the Outcomes and Assessment Information Set (OASIS) initiative to develop outcome measures aimed at improving the quality of home health services. OASIS collects longitudinal information on 79 patient-based, health-related quality indicators. HCFA anticipates the release of the final Conditions of Participation, that will require the use of OASIS for Medicare and Medicaid-certified home health agencies, in the second half of 1998.

What Lies Ahead?

Introduction of a prospective hospital payment system in Medicare contributed to a trend of shorter hospitalizations and to other changes, probably including rapid and relatively unregulated growth in home health care expenditures, while setting in motion major reorganization within hospital care itself. This and the persistent pressure for cost containment in every segment of health care has led to the impending implementation of prospective payment for home health services. If past is prologue, we can anticipate that policy makers will soon be faced with some critical questions: Despite best intentions, will home health agencies be driven to limit access and compromise quality? Will information systems be adequate to track the impact of the change on access and health? With Medicare rates less attractive, will there be upward pressure on Medicaid rates? Will independent, non-profit agencies seek refuge in alliances with for-profit chains or other partners with deeper pockets? Should we expect the "balloon" of health care costs to bulge at other edges such as nursing home costs and family caregiver burden, as we try to restrain home health costs? As the home health sector continues to evolve, answers will become more apparent, and policy remedies may necessarily involve not just this area, but all of the interrelated areas of health care.

Endnotes

Further Reading

Did you know?

New Information on Hospital Trends

The downward trend in hospital discharges may have leveled off in 1997. The Division of Health Care Finance and Policy's 1997 data base contains 764,000 discharge records from 83 Massachusetts acute care hospitals, a drop of over 100,000 discharges since 1991 and 1992 when total discharges reached nearly 900,000 annually. The Division will continue to monitor this data to confirm whether the decline is indeed leveling.

Other data findings:

- Asthma continues to be the most frequent principal diagnosis among hospitalized children age 1-17 accounting for nearly 30% of the 9,200 asthma admissions in 1997.
- Heart transplant hospitalizations were the most expensive cases with average charges of $250,000 per patient compared with $10,000 for acute patients overall. Most of the 63 heart transplant patients in 1997 were age 25-44 and about 41% of these patients resided outside Massachusetts.
- 107 very low birthweight neonates were the second most expensive cases with average charges of $235,000 and a three month hospital stay.
- Falls among the elderly age 65 and older represented almost two-fifths of the 38,000 nonmedical injury related discharges accounting for about $170,000,000 acute hospital inpatient dollars. Eighty percent of falls among the elderly were in the age 75 and older group, while those age 65-74 accounted for the other 20%. Most of these patients needed further care in subacute facilities or at home and continued to accrue charges beyond the $170,000,000 in acute care charges.